Chien Tham Kong v Excellent Strategy Sdn Bhd & Ors

HIGH COURT (MELAKA) — CIVIL SUIT NO 22–90 OF 2000
LOW HOP BING J
14 MAY 2008

Professions — Medical practitioners — Negligence — Nature of duty of care owed to patients — Whether existence of such duty a mixed question of law and fact — Whether Rogers or Bolam test applicable in Malaysia — Whether courts or medical profession to decide on liability of doctors in event of negligence

Professions — Medical practitioners — Negligence — Patient suffering from rare disease not easy to diagnose and treat — Disease presenting symptoms similar to a common condition — Whether unreasonable for doctor to first suspect rare disease

Tort — Negligence — Duty of care — Medical practitioners — Patient suffering from rare disease not easy to diagnose and treat — Disease presenting symptoms similar to a common condition — Whether unreasonable for doctor to first suspect rare disease — Whether Rogers or Bolam test applicable in Malaysia — Whether courts or medical profession to decide on liability of doctors in event of negligence

Tort — Negligence — Duty of care — Medical practitioners, nature of duty of care owed — Whether existence of duty of care a mixed question of law and fact

The 41 year old diabetic plaintiff, reporting a three-week history of lower back pain, was admitted to a hospital managed by the first defendant ('the hospital') on 15 March 1998. He was seen by the second defendant, a consultant orthopaedic surgeon. During this first admission, the plaintiff underwent physiotherapy for his lower back pain. The plaintiff was also referred to the third defendant, a consultant physician and gastroenterologist for management of his gastritis and diabetes mellitus. The plaintiff did not undergo any examination to rule out any infection. The plaintiff was discharged well on 18 March 1998. The plaintiff returned to see the second defendant on 20 March 1998, complaining of a pain at the neck. The second defendant prescribed conservative treatment which included physiotherapy, after which the plaintiff returned home. The plaintiff was admitted to the hospital again on 24 March 1998, having experienced weakness of his right

limbs and sweating the night before. The plaintiff was examined by the third defendant and managed on a provisional diagnosis of a stroke. On 26 March 1998, the plaintiff's neurological condition worsened and he became a paraplegic. An MRI scan of the brain revealed that the plaintiff did not suffer a stroke. A subsequent MRI scan of the neck revealed a cervical epidural abscess, a very rare type of infection in the cervical epidural spine, which was drained in an urgent operation on the night of 26 March. The plaintiff sued the defendants alleging negligence on the part of the second and third defendants. Against the second defendant, the plaintiff alleged a failure to take any proper precaution to prevent injury to the plaintiff's spinal cord. Against the third defendant, the plaintiff alleged negligence in making the initial diagnosis of stroke without considering an alternative diagnosis.

Held, dismissing the plaintiff's claim with costs:

(1) The plaintiff had filed his claim with scant regard for the factual situation. He proceeded to trial without first taking relevant independent expert medical advice. Nevertheless, the court would consider the merits or otherwise of the plaintiff's claim (see para 34).

(2) At common law the duty of care owed by a doctor arises out of his relationship with his patient, and that duty is to diagnose, advise and treat his patient. The existence or otherwise of a duty of care is a mixed question of law and fact and dependent on the evidence adduced at the trial in each particular case. The categories of medical negligence, like other negligence cases, are limitless and never closed. In the instant case, the second and third defendants clearly owed the plaintiff a duty of care — he was their patient (see paras 40–42); *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 followed.

(3) In Malaysia, the *Rogers* test is applicable by virtue of *Foo Fio Na v Dr Soo Fook Mun & Anor*, which preferred the *Rogers* test to the *Bolam* test. The *Rogers* test dictates that the court and not the medical profession must decide on the liability of doctors who are defendants in medical negligence actions. In so deciding, the court is at liberty to reject medical expert evidence which does not stand up to logical analysis. The court must instead scrutinise and evaluate the relevant evidence in order to adjudicate on the appropriate standard of care. Due regard must be had to the relevancy of the opinion of experts in line with s 45(1) of the Evidence Act 1950. In the instant case, the opinions of doctors skilled in medical specialties concerning spinal cords, neurology and stroke would be relevant (see para 60).

(4) Cervical epidural abscess is a very rare type of infection in the cervical epidural spine which defies early diagnosis and treatment. In the instant case, it would have been very difficult to even consider the possibility of cervical epidural abscess when the plaintiff presented signs and symptoms consistent with a stroke. It was unreasonable for a doctor to first suspect a rare condition when the symptoms and signs presented by a patient pointed to a different but much more common condition (see paras 69, 79 & 100).

(5) In the instant case, applying the *Foo Fio Na* test and upon the court's close scrutiny, evaluation and logical analysis, the professional conduct of the second and third defendants was consistent with the appropriate standard of care expected to be exercised by either of them as specialists. The plaintiff had failed to establish that the third defendant had not exercised the standard of care in his diagnosis and treatment of the plaintiff. The first defendant's vicarious liability did not arise as no liability had been attributed to the second and third defendants (see paras 101–102).

[Bahasa Malaysia summary

Plaintif pesakit diabetes berumur 41 tahun telah mengadu sakit belakang sejak tiga minggu dan dimasukkan ke hospital yang diuruskan oleh defendan pertama ('hospital tersebut') pada 15 Mac 1998. Dia dirawat oleh defendan kedua, seorang doktor pakar bedah ortopedik. Semasa kali pertama dimasukkan, plaintif menjalani fisioterapi untuk sakit belakangnya. Plaintif juga telah dirujuk kepada defendan ketiga, pakar perubatan dan gastroenterologi untuk mengawal gastritis dan diabetes mellitusnya. Plaintif tidak menjalani apa-apa pemeriksaan untuk mengetepikan apa-apa jangkitan. Plaintif telah dibenarkan keluar pada 18 Mac 1998. Plaintif telah kembali untuk berjumpa defendan kedua pada 20 Mac 1998, mengadu sakit leher. Defendan kedua telah mempreskripsikan rawatan konservatif termasuk fisioterapi, di mana selepas itu plaintif telah pulang ke rumah. Plaintif telah dimasukkan ke hospital sekali lagi pada 24 Mac 1998, setelah berasa lemah pada kaki kanannya dan berpeluh malam sebelumnya. Plaintif telah diperiksa oleh defendan ketiga dan membuat diagnosis strok. Pada 26 Mac 1998, keadaan neurologi plaintif bertambah teruk dan dia menjadi paraplegik. Imbasan MRI kepada otak menunjukkan bahawa plaintif tidak mengalami strok. Imbasan MRI selanjutnya menunjukkan abses epidura serviks, sejenis jangkitan yang jarang berlaku pada tulang belakang epidura serviks, yang telah dibuat dalam pembedahan kecemasan pada malam 26 Mac itu. Plaintif telah menyaman defendan-defendan mengatakan berlaku kecuaian di pihak defendan kedua dan ketiga. Terhadap defendan kedua, plaintif mendakwa kegagalan untuk mengambil apa-apa langkah mencegah yang betul untuk menghalang kecederaan kepada saraf tunjang plaintif. Terhadap defendan

ketiga, plaintif telah mengatakan berlaku kecuaian membuat diagnosis awal strok tanpa mempertimbangkan diagnosis alternatif. A

Diputuskan, menolak tuntutan plaintif dengan kos: B

(1) Plaintif telah memfailkan tuntutannya dengan kurang perhatian pada keadaan faktual. Dia telah meneruskan dengan perbicaraan tanpa terlebih dahulu mengambilkira nasihat pakar perubatan berasingan yang berkaitan. Meskipun begitu, mahkamah akan mengambilkira merit atau tuntutan plaintif sebaliknya (lihat perenggan 34). C

(2) Dalam *common law*, kewajipan berjaga-jaga oleh seorang doktor timbul daripada hubungannya dengan pesakit dan kewajipan tersebut adalah untuk mendiagnosis, menasihati dan merawat pesakitnya. Kewujudan atau kewajipan berjaga-jaga sebaliknya merupakan campuran persoalan undang-undang dan fakta dan bergantung kepada keterangan yang dikemukakan semasa perbicaraan dalam setiap kes tertentu. Kategori kecuaian perubatan, seperti kes kecuaian lain, tidak ada batasnya dan tidak tertutup. Dalam kes ini, defendan kedua dan ketiga jelas mempunyai kewajipan berjaga-jaga terhadap plaintif — dia merupakan pesakit mereka (lihat perenggan 40–42); *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 diikut. D E

(3) Di Malaysia, ujian *Rogers* adalah terpakai menurut kes *Foo Fio Na v Dr Soo Fook Mun & Anor* yang lebih berpihak kepada ujian *Rogers* daripada ujian *Bolam*. Ujian *Rogers* menyatakan bahawa mahkamah dan bukan profesion perubatan yang perlu memutuskan liabiliti doktor yang merupakan defendan dalam tindakan kecuaian. Dalam membuat keputusan, mahkamah bebas untuk menolak keterangan pakar perubatan yang tidak mengakui analisis secara logik. Mahkamah hendaklah sebaliknya meneliti dan menilai keterangan berkaitan bagi tujuan mengadili piawai berjaga-jaga yang sesuai. Perhatian sewajarnya perlu diberikan terhadap kaitan pendapat pakar sejajar dengan s 45(1) Akta Keterangan 1950. Dalam kes ini, pendapat doktor yang mahir dalam bidang perubatan berkaitan saraf tunjang, neurologi dan strok adalah relevan (lihat perenggan 60). F G H

(4) Abses epidura serviks adalah sejenis jangkitan yang jarang berlaku pada tulang belakang epidura serviks yang melawan diagnosis awal dan rawatan. Dalam kes ini, adalah sukar untuk mempertimbangkan kemungkinan abses epidura serviks apabila plaintif menunjukkan tanda dan gejala yang konsisten dengan strok. Adalah tidak munasabah untuk seorang doktor mensyaki pada mulanya keadaan yang luar biasa apabila gejala dan tanda yang ditunjukkan oleh pesakit menunjukkan suatu yang berbeza tetapi keadaan yang biasa berlaku (lihat 69, 79 & 100). I

(5) Dalam kes ini, dengan memakai ujian *Foo Fio Na* dan setelah mahkamah membuat penelitian, penilaian dan analisis yang logik, perlakuan profesional defendan kedua dan ketiga adalah konsisten dengan piawai berjaga-jaga sesuai yang dijangka digunakan oleh mereka sebagai doktor pakar. Plaintif telah gagal membuktikan bahawa defendan ketiga tidak menggunakan piawai berjaga-jaga dalam diagnosis dan rawatannya ke atas plaintif. Liabiliti vikarius defendan pertama tidak timbul kerana tiada liabiliti telah berpunca daripada defendan kedua dan ketiga (lihat perenggan 101–102).]

Notes

For cases on duty of care, see 12 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 963–1011.

For cases on negligence of medical practitioners, see 10 *Mallal's Digest* (4th Ed, 2005 Reissue) paras 1624–1633.

Cases referred to

Asiah bte Kamsah v Dr Rajinder Singh & Ors [2002] 1 MLJ 484; [2001] 4 CLJ 269, HC (refd)

Battersby v Tottman (1984) 35 SASR 557, SC (refd)

Best v Wellcome Foundation Ltd [1994] 5 Med LR 81 (refd)

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, HL (refd)

Bolitho (administratrix of the estate of Bolitho, deceased) v City and Hackney Healty Authority [1997] 4 All ER 771, HL (refd)

Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45, PC (refd)

Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals [1998] 1 MLJ 57, CA (refd)

Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171, HC (refd)

F v R (1983) 33 SASR 189, SC (refd)

Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229, FC (folld)

Gascoine v Ian Sheridan & Co [1994] 5 Med LR 437 (refd)

Hajgato v London Health Association (1982) 36 OR (2d) 669 (refd)

Har Sai Hong & Anor v University Hospital & Anor [2001] 8 CLJ 208, HC (refd)

Hucks v Cole [1993] Med LR 393, CA (refd)

Joyce v Wandsworth Health Authority [1995] 6 Med LR 60 (refd)

Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor [1996] 4 MLJ 674; [1997] 5 CLJ 250, HC (refd)

Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128, FC (refd)

Lechemanavasagar a/l Karuppiah v Dr Thomas Yau Pak Chenk & Anor [2008] 1 MLJ 115, HC (refd)

Liew Sin Kiong v Dr Sharon DM Paulraj [1996] 5 MLJ 193; [1996] 2 CLJ 995, HC (refd)
Naxakis v Western General Hospital & Anor [1999] HCA 22, HC (refd)
R v Bateman (1925) 94 LBKB 791, CCA (refd)
Rogers v Whitaker (1992) 175 CLR 479, HC (refd)
Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors [1985] 1 AC 871, HL (refd)
Swamy v Matthews & Anor [1967] 1 MLJ 142, HC (refd)
Swamy v Matthews & Anor [1968] 1 MLJ 138, FC (refd)
Tan Ah Kau v The Government of Malaysia [1997] 2 CLJ Supp 168, HC (refd)

Legislation referred to
Evidence Act 1950 s 45(1)

Sharmini Navaratnam (Siva Dharma & Associates) for the plaintiff.
S Kanagasabapathi (Dass, Jainab & Associates) for the first defendant.
PS Ranjan (MS Dhillon with him) (PS Ranjan & Co) for the second and third defendants.

Low Hop Bing, J:

THE PLAINTIFF'S CLAIM

[1] The plaintiff's claim is based on:

(a) vicarious liability against Excellent Strategy Sdn Bhd ('the first defendant') as the party having care and control of Mahkota Medical Centre ('the hospital');

(b) negligence of the second defendant Dr Lim Ah Tee ('Dr Lim') who in providing treatment was alleged to have failed to take any proper precaution to prevent injury to the plaintiff's spinal cord; and

(c) negligence of the third defendant Dr Chow Ken Tek ('Dr Chow') who was alleged to have made an initial diagnosis of stroke based on the plaintiff's presenting symptoms without making, or considering an alternative diagnosis, or referring to a specialist capable of making an alternative diagnosis.

THE FACTS

[2] After a full trial, the narrative of my finding of facts may be unfolded below. All the events described hereinafter took place in 1998, unless otherwise stated.

A **[3]** In 1998, the 41 year-old plaintiff worked as a freelance estate broker in Melaka.

[4] Sometime in February, the plaintiff carried some weights and developed back pain.

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[5] In March, the plaintiff consulted a general practitioner, Dr Lee Jon Kwang (SP4) who treated the plaintiff for fever and backache on 9 and 10 March. Upon noting glucose in the plaintiff's urine on 14 March, SP4 ordered a blood test which confirmed that the plaintiff suffered from diabetes, and prescribed medication for treatment thereof.

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[6] On 15 March, the plaintiff went to the accident and emergency department of the hospital ('A and E department') for treatment. He was seen by Dr Lim, a consultant orthopaedic surgeon, who noted that the plaintiff had been told earlier that he (the plaintiff) had diabetes mellitus recently.

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[7] When the plaintiff saw Dr Lim, he had a three-week history of lower backache and was treated by Dr Lim. The plaintiff was hospitalised from 15 to 18 March ('the first admission').

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[8] Dr Lim treated the plaintiff for lower backache and referred him to Dr Chow for management of his gastritis and diabetes mellitus.

F **[9]** Although the plaintiff testified that he only found out that he was a diabetic when he saw SP4 in March, there was evidence from Dr Chow, a consultant physician and gastroenterologist who stated in his medical report, exh D9, that the plaintiff's diabetes mellitus was apparently diagnosed about 10 years earlier, and the plaintiff was only on dietary control.

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[10] During the first admission, the plaintiff underwent physiotherapy for the lower backache. His pulse rate and glucose levels were high. He had a history of recent weight loss, poor appetite and slept poorly overnight on 17 March.

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[11] No investigation to rule out infection was carried out.

[12] When the plaintiff was discharged on 18 March, Dr Chow requested the plaintiff to return for outpatient physiotherapy and review within one week.

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[13] The plaintiff returned as an outpatient on 20 March. He saw Dr Lim and complained of pain at the neck but with no fever. Dr Lim undertook conservative treatment which included physiotherapy, after which the plaintiff returned home.

[14] On 23 March at 9pm, the plaintiff suffered sudden weakness of his right limbs and was sweating.

[15] The plaintiff returned to the A and E department at 10.30am on 24 March and was admitted until 16 May ('the second admission'). It was recorded that the plaintiff had a high pulse rate of 115 and was having a temperature of 38°C. Having examined the plaintiff and considered the plaintiff's history, Dr Chow suspected that the plaintiff had suffered a stroke and ordered a CT scan of the brain. At 11.45am on 24 March, it was recorded that no infarct was seen. The patient was managed on provisional diagnosis of a stroke.

[16] The plaintiff's condition was stable. When Dr Chow saw the plaintiff at 6.20pm on 24 March, he noted that the plaintiff could not pass urine and was having fever. The glucose level was elevated. Nursing notes on the plaintiff's admission to the ward in the morning do not record the vital signs. The afternoon entry (third column) shows that the plaintiff was having fever and that a catheter was inserted.

[17] The temperature chart shows that the plaintiff's fever and pulse rate were elevated on 24 to 26 March.

[18] The 8.45am entry on 25 March by Dr Chow shows the plaintiff was still having fever and an elevated glucose level (9.4 mmol.l). There was a note 'please feed patient' which indicates that the plaintiff's condition was not good and remained as such on 24 and 25 March.

[19] On 25 March, veneral disease research laboratory investigations were undertaken and the plaintiff showed some signs of improvement. He was noted to be 'eating more'. The neurological condition remained the same.

[20] On 26 March, the plaintiff's neurological condition worsened. He was unable to move his right lower limb and had difficulty in swallowing. His fever had increased. On seeing this, Dr Chow planned a series of investigations, including an MRI scan of the brain and a Doppler ultrasound examination of the neck vessels. The MRI result was negative.

[21] The respective evidence of plaintiff's friend Dr Eng Ji Bah (SP3), a consultant cardio-thoracic surgeon, Dr Lee Jon Kwan (SP4) and Dr Mohd Nor Manukaran (SP5) adduced for the plaintiff do not concern the issue of the cervical epidural abscess, nor on liability.

[22] SP5 testified that her husband's condition was very bad and had high fever on 25 March.

[23] SP3 attempted to contact Dr Chow in the hospital at 10pm on 25 March, and suggested that the plaintiff be seen by Dr Ashok Philip (SD4), a consultant physician with an interest in neurology.

[24] On 26 March at 8.20am, Dr Chow saw the plaintiff and noted that the plaintiff had worsening neurological deficit, increased fever and difficulty in swallowing. The blood sugar was elevated to 10.3 mmol.l. At this point in time, Dr Chow referred the plaintiff to Dr Ashok Philip, as requested by the plaintiff's family.

[25] Dr Ashok Philip noted that 'this stepwise progression of disease is worrying'. He reviewed the MRI of the brain which showed it was normal in the morning of 26 March, confirming that the plaintiff had not suffered a stroke. He then conducted a lumbar puncture on the plaintiff to exclude meningitis, and on 26 March, the lumbar puncture result was negative.

[26] At 2.45pm on 26 March, Dr Chow noted worsening of the plaintiff's neurological condition, as the right hemiparesis was worsening and there was no sensory level. Dr Chow then ordered a MRI scan of the neck (cervical spine and upper thoracic spine). The MRI showed 'Abscess seen in epidural and subdural space extending from C1-T1 vertebrae levels'.

[27] Dr Chow referred the plaintiff to neurosurgeon Dr Chee Wee Liam (SP2) ('Dr Chee') at 5.20pm on 26 March. When Dr Chee saw the plaintiff in the evening of 26 March, the plaintiff was paraplegic — 0/5 bilaterally and noted that anal tone was lax (faecal incontinence) and on urinary cathether. The plaintiff underwent urgent decompression surgery conducted by Dr Chee at 10.45pm on 26 March to drain the epidural and subdural abscess. The MRI undertaken earlier that day showed suspicion of an abscess, which could only be confirmed at the operation.

[28] The plaintiff was seen on and off by Dr Chow at the hospital on several occasions until 28 December 1999, essentially in relation to his diabetes and gastritis.

[29] Other finding of facts will follow later in this judgment as and when necessary in considering the issues raised in submissions.

PLEADINGS

[30] In relation to the plaintiff's pleadings, the second and third defendants' learned counsel Mr PS Ranjan (Mr MS Dhillon with him) submitted that the plaintiff's statement of claim is inconsistent with a large part of the evidence; and that the plaintiff has filed his claim and proceeded to trial without first taking relevant independent expert medical advice.

[31] I am unable to find any reply by plaintiff's learned counsel Ms Sharmini Navaratnam to the aforesaid submission.

[32] My perusal of and observations on the relevant averments in the plaintiff's statement of claim as tested against the evidence adduced at the trial may be tabulated as follows:

Paragraph in the statement of claim	Averment	Evidence
11	Severe pain at the neck, high fever and pain at the back.	Dr Lim's evidence revealed only a history of pain at the neck, but there was no fever and no further complaint of the earlier lower back pain recurring.
13	When the plaintiff returned home on 20 March, he suffered 'difficulty in moving and pain'.	This averment suggests that on 20 March the plaintiff had a neurological problem, but on 20 March he was an outpatient and saw Dr Lim and complained of pain at the neck. He did not see any doctor between 21 and 24 March.

15	The plaintiff suffered symptoms of paralysis	The history given by the plaintiff to Dr Chow on 24 March was that he had 'sudden onset of weakness of right limbs and sweating at 9.00pm last night' which means that such weakness had first occurred only on the night of 23 March, three days after the plaintiff saw Dr Lim with pain at the neck, on 20 March.
20	The MRI of the cervical spine was 'conducted' by Dr Ashok Philip on 26 March.	Dr Ashok's evidence showed that the MRI scan was ordered by Dr Chow, while Dr Ashok only undertook a lumbar puncture procedure on 26 March.

[33] The plaintiff's statement of claim made common allegations of negligence against all the three defendants although Dr Lim did not see the plaintiff during the second admission from 24 March to 16 May and Dr Chow did not see the plaintiff during the out patient visit on 20 March.

[34] The averments in the plaintiff's statement of claim and common allegations of negligence show that the plaintiff had filed his claim with scant regard for the factual situation. Although he has proceeded to trial without first taking relevant independent expert medical advice, I shall proceed to consider the merits or otherwise of the plaintiff's claim.

BURDEN OF PROOF

[35] Broadly speaking, the plaintiff bears the burden of proving negligence against the three defendants on a balance of probabilities: see eg *Tan Ah Kau v The Government of Malaysia* [1997] 2 CLJ Supp 168 at p 189 (HC); *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals* [1998] 1 MLJ 57 (CA); and *Lechemanavasagar a/l Karuppiah v Dr Thomas Yau Pak Chenk & Anor* [2008] 1 MLJ 115 (HC).

[36] Harking back to first principles, in order to succeed in a claim for negligence against Dr Lim or Dr Chow, it is incumbent on the plaintiff to prove that:

(1) Dr Lim or Dr Chow owe the plaintiff a duty and standard of care;

(2) Dr Lim or Dr Chow has breached that duty;

(3) as a result of the breach, the plaintiff has suffered damages; and

(4) the damages are not too remote.

[37] If the plaintiff succeeds in the claim against either Dr Lim or Dr Chow or both, then as against the first defendant, the plaintiff bears the burden of proving that the third defendant is vicariously liable for the negligence of the doctors.

[38] On the other hand, the first defendant's vicarious liability would not arise if the plaintiff fails to establish his claim against both the doctors or either of them.

DUTY OF CARE

[39] In relation to Dr Lim or Dr Chow, their duty of care as doctors is governed by common law principles which had been succinctly stated by Lord Hewart CJ in *R v Bateman* (1925) 94 LBKB 791 as follows:

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.

[40] The above passage was accepted by our Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 in para [25] p 601 (MLJ) and para [27] p 243 (CLJ): per Siti Norma Yaakob FCJ (later CJ (Malaya)). The Federal Court also explained that at common law the duty of care owed by a doctor arises out of his relationship with his patient, and that duty is to diagnose, advise and treat his patient.

[41] In applying the above principle, I also take the position that the existence or otherwise of a duty of care is a question of mixed law and fact. The answer lies in the evidence adduced at the trial in each particular case where the factual matrix prevails. The categories of medical negligence, like other negligence cases, are limitless and hence never closed.

[42] In the instant case I hold that Dr Lim and Dr Chow owe the plaintiff a duty of care as their patient. I now proceed to consider the standard of care.

STANDARD OF CARE

[43] The fulfilment or otherwise of standard of care in medical negligence

A cases is essentially a common law phenomenon. The past 50 years saw the emergence of two different tests governing the standard of care which is expected to be exercised by a doctor in the diagnosis, advice and treatment of a patient.

B STANDARD OF CARE: FIRST TEST

[44] The *first test* commonly known as 'the *Bolam test*' was established by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118. The principles that may be culled therefrom are:

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(1) Where a situation involves the use of some special skill or competence, the test whether or not there has been negligence is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill, but it is the test of the ordinary skilled man exercising and professing to have that special skill; and

D

(2) A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a respectable body of medical men skilled in that particular art although there is a body of opinion taking a contrary view.

E

[45] The *Bolam test* in substance restrains the courts from scrutinising and evaluating the professional conduct of a doctor possessed of a special skill and competence and dictates that he is not negligent if he has acted within a practice accepted as proper by a body of his own peers who possess similar skill and competence as the doctor in question. It matters not that there exists another body with a differing opinion that does not accept the action taken by the doctor. It is enough that he had acted in accordance with one of the bodies of opinion and the courts can never declare his action to be in any way negligent. This over protective and deferential approach perhaps conforms to the well known phrase that 'A doctor knows best': see *Foo Fio Na*, at p 243 (CLJ).

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[46] The *Bolam test* was applied eg in:

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(1) the majority judgment of the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital & Ors* [1985] 1 AC 871;

(2) *Swamy v Matthews & Anor* [1967] 1 MLJ 142 (HC) and *Swamy v Matthews & Anor* [1968] 1 MLJ 138 (FC); (see *Fo Fio Na*, p 253 para 60 (CLJ));

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(3) *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45;

(4) *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171;

(5) *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128;

(6) *Asiah bte Kamsah v Dr Rajinder Singh & Ors* [2002] 1 MLJ 484; [2001] 4 CLJ 269 (HC);

(7) *Har Sai Hong & Anor v University Hospital & Anor* [2001] 8 CLJ 208 (HC);

(8) *Liew Sin Kiong v Dr Sharon DM Paulraj* [1996] 5 MLJ 193; [1996] 2 CLJ 995 (HC); and

(9) *Dr Chin Yoon Hiap* (CA).

[47] It needs to be noted that the *Bolam test* has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient, on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient, who is capable of understanding and appreciating such information, of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment: *Foo Fio Na*.

BOLAM TEST DISCOUNTED

[48] The *Bolam test* has been discounted by Michael Jones in *Medical Negligence* (1996 Ed) at p 95 on the ground that it fails to make the important distinction between the reasonable competent doctor and the ordinary skilled doctor. The author advocated such a distinction whereby a reasonable, competent doctor is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor', while an ordinary skilled doctor places considerable emphasis on the standards which are in fact adopted by the profession. The author said that it is for the court to determine what the reasonable doctor would have done, not the profession, and what the profession does in a given situation will be an important indicator of what ought to have been done but it should not necessarily be determinative as the court should finally set the standard of care in negligence, drawing upon the evidence presented.

[49] A court has the right to strike down substandard approved practices when common sense dictates such a result, and no profession is above the law, as the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards: see *Hajgato v London Health Association* (1982) 36 OR (2d) 669, per Callaghan J.

[50] The function of the court is to acquire a just result, to apply common sense and a careful understanding of the logical and likelihood of events to conflicting opinions and conflicting theories: *Best v Wellcome Foundation Ltd* [1994] 5 Med LR 81, per Finlay CJ.

STANDARD OF CARE: SECOND TEST

[51] In *Sidaway*, the dissenting speech of Lord Scarman set the scene for the *second test* which was further developed in *Rogers v Whitaker* (1992) 17 CLR 479 and *Bolitho (administratrix of the estate of Bolitho, deceased) v City and Hackney Healty Authority* [1997] 4 All ER 771. The learned Law Lord declined to apply the *Bolam test* and opined:

> In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.

[52] The second test was applied in *Hucks v Cole* [1993] Med LR 393, where the English Court of Appeal held that it was appropriate for judges to reject medical expert evidence if they do not really stand up to analysis.

[53] Earlier indications of applying the second test were expressed by the Supreme Court of South Australia in *F v R* (1983) 33 SASR 189 and *Battersby v Tottman* (1984) 35 SASR 557, at p 582, where the courts there refused to be bound as a matter of course by the evidence on the practice of the medical profession but went on to question and scrutinise the professional practice, to ensure that the standard set by law is attained: see *Foo Fio Na*.

[54] A similar sentiment was shown in *Gascoine v Ian Sheridan & Co* [1994] 5 Med LR 437; and *Joyce v Wandsworth Health Authority* [1995] 6 Med LR 60.

[55] The most authoritative exposition of the second test was enunciated by the House of Lords in *Bolitho*. At p 778, Lord Browne Wilkinson, speaking for the House, opined that:

(1) the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice;

(2) In the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds the question of comparative risks and benefits and have reached a defensible conclusion on the matter;

(3) In cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence, because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible; and

(4) If, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[56] In 1992, the second test found support in Australia. In *Rogers v Whitaker* (1992) 175 CLR 479 where the first test ie the *Bolam test* was rejected, both in the sphere of diagnosis and treatment; and in the field of non-disclosure of risk in the provision of advice and information. The Supreme Court of New South Wales, the Court of Appeal and ultimately the High Court of Australia followed the dissenting speech of Lord Scarman in *Sidaway*, supra. The High Court of Australia held that the standard of care is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the profession, and the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make his own decisions about his life'. This is now commonly known as the *Rogers test*.

[57] In *Naxakis v Western General Hospital & Anor* [1999] HCA 22, the High Court of Australia reaffirmed that the question of medical negligence in the areas of diagnosis, treatment and duty to warn (ie advice) is a question for the court, and the duty of deciding it could not be delegated to any profession or group in the community: see also *Foo Fio Na*.

[58] The *Rogers test* has found considerable following in Malaysia, as illustrated in:

(1) *Kamalam a/p Raman & Ors v Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor* [1996] 4 MLJ 674; [1997] 5 CLJ 250, where Richard Talalla J (as he then was) also applied the majority judgment of the Federal Court in *Swamy v Matthews & Anor* at pp 139–140 per Barakhbah LP (as he then was); (see also *Foo Fio Na*, p 255);

(2) *Tan Ah Kau v The Government of Malaysia*, by me; and

(3) *Lechemanavasar a/l S Karuppiah* by Rohana Yusuf J in relation to the issue of whether the doctor was negligent in the after-care post-operation and the infection in the plaintiff's right lung pleural thorax cavity p 122.

[59] The *Rogers test* gained recognition in *Foo Fio Na*, where our Federal Court held that there is a need for members of the medical profession to stand up to the wrong doings, if any, and in so doing, people involved in medical negligence cases would be able to obtain better professional advice and the courts would be appraised with evidence that would assist them in their deliberations. In the circumstances, the Federal Court preferred the *Rogers test* to the *Bolam test* as a viable test of this millennium, and observed that the phrase 'Doctor knows best' should now be qualified by: 'if he acts reasonably and logically and gets his facts right': per Lord Woolfe in the inaugural lecture in the new Provest Series, as applied by our Federal Court.

[60] Upon my analysis of the above authorities, I would apply the *Rogers test* which has been accepted by the Federal Court in *Foo Fio Na* as it is binding on me. This test dictates that the court and not the medical profession must decide on the liability of doctors who are defendants in medical negligence actions. In so deciding, our courts are at liberty to reject medical expert evidence which does not really stand up to logical analysis, but instead must scrutinise and evaluate the relevant evidence in order to adjudicate on the appropriate standard of care. Due regard must be had to the relevancy of the opinion of experts in line with s 45(1) of the Evidence Act 1950, which provides that when the court has to form an opinion upon a point of eg science, the opinions upon that point of persons specially skilled in that science are relevant facts. In the context of the instant case, the opinions of doctors specially skilled in medical science, with particular speciality in spinal cords, neurology and stroke are relevant.

[61] In relation to our common law on medical negligence, I would refer to the second test as the *Foo Fio Na* test to achieve local flavour. Having regard to the evidence adduced at the trial, I would now proceed to scrutinise

and evaluate the professional conduct of Dr Lim and Dr Chow in order to determine the issue of their liability.

CLAIM AGAINST DR LIM

[62] It was submitted for the plaintiff that Dr Lim's liability arises from his failure:

(1) to take any or any proper precaution to prevent injury to the plaintiff's spinal cord;

(2) to appreciate that the plaintiff was diabetic and that even a minor complaint like pain in the neck could be associated with an infection ie cervical epidural abscess;

(3) to tell the plaintiff that in the event the pain in the neck worsens or his condition becomes worse in any way, the plaintiff should immediately return to see him on the second admission; and

(4) to notify Dr Chow of the plaintiff's complaints of pain at the neck on 20 March 1998 in order that due attention could have been paid to the status of the neck, so that an MRI of the cervical spine could be done and the cervical epidural abcess diagnosed earlier.

[63] The plaintiff relied on para 29.43 and 29.44 in *Medical Negligence* (2nd Ed) by Michael J Powers and another.

[64] On the other side of the Bar table, it was submitted for Dr Lim that:

(1) the diagnosis of a cervical epidural abscess is difficult to make as it is a rare condition, as supported by Deardre Chao in *Spinal Epidural Abscess: A Diagnostic Challenge* 1 April 2002 and Richard H Rothman and Frederick A Simeone in *The Spine* p 1347; and

(2) Upon scrutiny and evaluation by the court, expert evidence adduced for Dr Lim showed that he has exercised the required standard of care and complied with a reasonable, respectable and responsible practice.

[65] Under this head, the question for determination is:

> Was Dr Lim liable to the plaintiff in negligence on ground of breach of the standard of care ie failing to take proper precaution to prevent injury to the plaintiff's spinal cord during the first admission from 15 to 18 March 1998, and the outpatient visit on 20 March 1998?

[66] The answer to this question rests on an analysis of the evidence adduced before me.

[67] The evidence revealed that during the first admission (15 to 18 March), the plaintiff had lower back pain but no fever; and he gave a history of lifting heavy objects; and that, following physiotherapy, he was discharged well on 18 March. The evidence did not show that the pain at the plaintiff's neck had worsened during the first admission from 15 to 18 March. The plaintiff had also not complained of pain at his neck or back, after the single episode of 20 March.

[68] On the issue of advising the plaintiff to return to the hospital, there is evidence that upon discharge on 18 March (after the first admission), the plaintiff continued with outpatient physiotherapy. That would require him to visit the hospital and to be referred to a doctor by the physiotherapist if the need arose. He was also to see Dr Chow on 25 March. The plaintiff had indeed been informed of these appointments for purposes of medical surveillance or follow-up. The plaintiff went back to the hospital on 24 March, a day before his appointment with Dr Chow, and complained of one-sided weakness of the limbs. He was attended to without delay.

[69] Although the plaintiff tried to suggest that there were enough signs and symptoms to alert Dr Lim and Dr Chow to the possibility of a cervical epidural abscess, during his first admission and second admission to the hospital, the plaintiff was having a very rare type of infection in the cervical epidural spine which defies early diagnosis and treatment.

[70] Despite having weakness in his hands and legs from 20 March, he sought admission to the hospital on 24 March only. However, the plaintiff had not pleaded the allegation of weakness commencing from 20 March and did not support his evidence in the form of medical records.

[71] In the insurance claim form, the plaintiff stated that the weakness in his limbs had started on 24 March.

[72] During the second admission on 24 March, the plaintiff had fever and weakness in his right limbs; on 25 March he was able to eat more; and on 26 March, he had increased fever and worsening of neurological deficit. The plaintiff had no complaint of back pain or pain at the neck. Even when Dr Ashok undertook the lumbar puncture, the plaintiff was able to lie in a foetal position which required him to extend his neck and yet no complaint was made by him to Dr Ashok of any neck pain. Dr Ashok also did not see any redness, tenderness and swelling of the neck.

[73] Although the plaintiff has allegedly seen three doctors on first admission and four doctors on second admission and had complained about redness and swelling of his neck, there was not a single medical record

regarding that complaint. The balance of probabilities does not support the plaintiff's evidence that his neck was having redness and swelling.

[74] Neurosurgeon Dr Chee (SP2) who testified for the plaintiff explained that the presenting systems and signs vary from one patient to another, although they all have the same illness; and that the 'non-specific' and 'highly variable' presentation of spinal epidural abscess made it difficult to make an early diagnosis in the instant case. The lower back pain during the first admission does not translate into the cervical epidural abscess found during the second admission. On 24 March, if the patient ie the plaintiff had presented to him with such signs or symptoms, his provisional diagnosis would be that of stroke.

[75] Although Dr Chee testified that a stroke could have been confirmed earlier than 26 March, he did not say that the different condition of a cervical epidural abscess could have been confirmed earlier than it was on 26 March.

[76] Dr Chow had no difficulty in undertaking a gastroscopy procedure on the plaintiff on 17 March which required the plaintiff to flex his neck and he did not complain of any neck pain during the gastroscopy procedure.

[77] On 24 and 25 March, the plaintiff had fever and right-sided neurological deficit. He had no more back pain or neck pain. A diagnosis of stroke was made.

[78] On 26 March, the plaintiff's fever increased and his neurological condition worsened. There were still no complaints of a back pain or neck pain. Dr Ashok undertook the lumbar puncture which would have required the plaintiff to extend his neck, and the plaintiff was able to do so without difficulty. Again, no complaint of a neck pain was made by the plaintiff.

[79] Even going by the entire evidence adduced for the plaintiff, it would have been very difficult to even consider the possibility of a cervical epidural abscess when the presenting signs and symptoms were more consistent with a stroke.

CLAIM AGAINST DR CHOW

[80] Under this head, the question for determination is:

> Was Dr Chow liable to the plaintiff in negligence by reason of a failure in the standard of care ie by making an initial diagnosis of stroke based on the plaintiff's presenting symptoms without making or considering an alternative diagnosis or referring to a specialist capable of making an alternative diagnosis?

[81] To recapitulate, the plaintiff testified that:

(1) he had redness of, tenderness in, and swelling around his neck from 20 March, which persisted during the second admission, until 26 March;

(2) he had pain at the neck during the first admission, but Dr Chow had successfully undertaken a gastroscopy, which required the plaintiff to flex his neck on 17 March with no difficulty; and

(3) he had fever during his out-patient visit on 20 March but Dr Lim had made a note that the plaintiff was 'afrebrile (no fever)' on 20 March.

[82] The plaintiff's complaint of having fever was not supported by any of the doctors including Dr Ashok and Dr Chee who attended to him. None of them had noted the alleged redness, tenderness and swelling that the plaintiff had testified about.

[83] It is clear that there was nothing in the evidence to remotely indicate that the plaintiff had a cervical epidural abscess during the first admission and during the out-patient visit on 20 March.

[84] In addition to the evidence analysed above, Dr Chow's also testified to the following effect:

(1) He made a provisional diagnosis of cerebro-vascular accident which is stroke, based on the presentation of right upper and lower limb weakness of sudden occurrence; and the plaintiff has diabetes mellitus which is a predisposing factor for stroke. The clinical symptoms and signs at presentation are consistent with stroke.

(2) He subsequently revised his provisional diagnosis to one of cervical epidural abscess. Between the provisional diagnosis of stroke and cervical epidural abscess, he also considered other diagnosis viz brain tumour and brain abscess. He found nothing in the presenting condition of the plaintiff to support a diagnosis of cervical epidural abscess.

(3) The clinical presentation was typical of a stroke. Cervical epidural abscess is a very rare condition. It is also very difficult to diagnose. In the absence of pain or swelling at the neck or other symptoms related to the neck, it would be highly speculative to make that diagnosis at presentation.

(4) He has seen hundreds of stroke but has so far seen one case of lumbar epidural abscess and that lumbar epidural abscess fortunately presented typical features of weakness of both lower limbs and back pain.

(5) He needed time for the stroke treatment to work because the available evidence at that time pointed to a diagnosis of stroke. All treatment instituted would obviously require some time to show its efficacy. In the absence of new evidence, he persevered with the treatment for stroke.

(6) On 24 and 25 March, there was no new evidence to justify ceasing the treatment for stroke.

(7) However, on 26 March, there was new evidence ie worsening of his weakness on the right side and the plaintiff had difficulty swallowing food. Dr Chow then changed his diagnosis in view of the plaintiff's worsened neurological condition showing that there was uncharacteristic deterioration in his symptoms. The MRI of the brain and the lumbar puncture results were reported to be negative, and the MRI of the cervical spine suggested an abscess.

[85] Dr Chow, Dr Ashok and Dr Chee had seen and attended to the plaintiff during the second admission. A lumbar puncture, an ultrasound of the neck, an MRI of the cervical spine, and an operation on the neck were undertaken during this admission. However, none of the doctors involved in such procedures reported any finding of a swelling of, tenderness in, or redness of the neck. None of them reported that the plaintiff had complained of pain at the neck.

[86] If indeed the plaintiff had pain at the neck, Dr Ashok would not have been able to successfully undertake the lumbar puncture, which required bending of the plaintiff's neck during the procedure.

[87] The plaintiff's allegations of tenderness in, redness and swelling of the neck, and of a continuation of pain at the neck during second admission were made because the true presenting signs and symptoms that the plaintiff had during both admissions would not have alerted any doctor to the remote possibility of a cervical epidural abscess. If the plaintiff had these complaints, which were allegedly ignored by the doctors in hospital, then it would have been reasonable for the plaintiff to discontinue his confidence in them. However, the plaintiff continued to see Dr Chow, and the last of such visit was made on 28 December 1999.

OTHER MEDICAL EVIDENCE ADDUCED FOR THE PLAINTIFF

[88] The scrutiny and evaluation of the evidence of Dr Lim and Dr Chow has to be considered in the light of the evidence of plaintiff's other witnesses.

[89] In relation to the common symptoms of cervical epidural abscess, Dr Chee (SP2) testified that normally, patients would present with pain at the

back of the neck in association with fever and varying degree of functional loss of both the upper and lower limbs together with sphincteric disturbances. This would be manifested by difficulty to micturate as well as to defaecate. In addition, it can also mean bladder and bowel incontinence. Such patients will also have restricted neck movement. However, Dr Chee conceded that:

(1) as a neurosurgeon, he could not comment on the professional actions of a physician or an orthopaedic surgeon; and

(2) if the patient presented to him on 24 March with such signs and symptoms, his provisional diagnosis would be that of stroke.

[90] Dr Chow had prescribed 'voltaren supp 450 mg stat' on 25 March. In this regard, the suggestion by the plaintiff's counsel that voltaren was prescribed for pain, was not agreed to by Dr Chee, adding that the inference that the reason for giving 'voltaren supp' solely for pain relief, may be misguided, because 'voltaren supp' can also be used for fever control.

EXPERT EVIDENCE ADDUCED FOR DR LIM AND DR CHOW

[91] Dr Lim and Dr Chow called two expert witnesses, viz consultant orthopaedic surgeon Dr Kuldip Singh Dhillon (SD3) and consultant neurologist Dr Lee Moon Keen (SD5).

[92] Dr Dhillon (SD3) testified to the following effect:

(1) The cervical epidural infection or infection of the spine was a rare condition, the least common of the spinal region and that he had not seen one.

(2) When the plaintiff was admitted to the hospital on the second occasion, he did not have sensory deficit. He had motor deficit when there was weakness in his right limbs. A motor deficit indicates a problem in the brain which causes a stroke, not an infection in the spine.

(3) When Dr Chow saw the plaintiff's case as one involving the brain ie a stroke on 24 and 25 March, he was apparently justified to do so. On 26 March, when there was worsening of the plaintiff's condition which necessitated further investigations, Dr Chow ordered, inter alia, an MRI of the neck and upper chest which showed the suspected cervical epidural abscess.

(4) In relation to the change in the plaintiff's condition on 26 March, the alleged redness and swelling of the neck was not a sign of epidural abscess.

(5) The neurological findings of 24 and 25 March indicated the involvement of the brain rather than the spinal cord and there was no change in the neurological deficit on 25 March.

(6) It is difficult to suspect spinal cord disease in the absence of positive neurological findings.

(7) The neurological findings on 24 and 25 March were purely motor in nature and pure motor deficit is usually an indicator of involvement of the brain rather than the spinal cord. In an involvement of the spine, usually a combination of motor and sensory deficit is present.

(8) In the absence of symptoms relating to the neck and the absence of sensory deficit, it becomes difficult to consider a diagnosis of infection in the neck.

(9) There is a vital distinction between sensory deficit and motor deficit.

(10) When there was evidence available on 26 March to suggest an alternative diagnosis of an infection of the spine, appropriate investigations were done to confirm that alternative diagnosis.

(11) Dr Chow had not delayed in diagnosing the cervical epidural abscess, because in patients where there is difficulty in diagnosis because of the rarity of the condition, the diagnosis is done in a sequential manner based on the clinical presentation day by day; and that on 24 March the most likely diagnosis was a stroke.

[93] The evidence of Dr Lee (SD5) may be narrated as follows:

(1) Dr Chow's investigation of the neck was done with due promptness without any delay, the defining feature of cervical epidural abscess is spinal pain which was not documented on 24 and 25 March. Without this localising feature, there was no indicator to diagnose cervical epidural abscess and that common things being common, all doctors are trained to look for common diseases before considering rare conditions.

(2) The plaintiff's chance of recovery were only about 40%.

(3) Weakness on one side of the body was caused by a problem in the brain in a vast majority of patients rather than the spinal cord. Therefore one would investigate for such problems in the brain initially.

(4) During the second admission, the plaintiff presented with weakness on the right side, not both sides, hence leading Dr Lim and Dr Chow to consider stroke as the cause of the weakness.

(5) On 20 March, the cardinal sign of infection which is fever was absent in the plaintiff who also did not complain of back pain on that day. Such complaint was made during the first admission on 15 March but did not persist following treatment.

(6) Back pain can be caused by many medical conditions and cervical epidural abscess is one of the rarest causes.

(7) Cervical epidural abscess is diagnosis by a combination of fever, spinal pain and neurological deficit. Based on the elevated pulse and sugar reading together with spinal pain, during the first admission and 20 March, together with the fever on 24 March and 25 March, the symptoms on the first admission, seem to be consistent with back strain, there being no fever and no neurological deficit.

(8) On the second admission the symptoms were fever, sweating and neurological deficit. Therefore Dr Chow had to investigate based in the prevailing set of circumstances.

(9) On the provisional diagnosis of a stroke, patients with stroke may show no noticeable improvement for several days and further tests are ordered only if there is possibility of a complication or deterioration in status in order to avoid unnecessary escalation of costs to the patient.

(10) The defining feature of cervical epidural abscess is spinal pain which was not documented on 24 and 25 March. Without this localising feature, there is no indicator to diagnose cervical epidural abscess.

(11) Until 26 March, there was no feature to indicate the rare condition of cervical epidural abscess up to that point and Dr Ashok Philip also did not deem it fit to investigate for cervical epidural abscess at that time.

(12) This condition is difficult to diagnose and treatment is fraught with delay in many cases.

(13) The plaintiff suffered a rare condition which was difficult to diagnose early. The presentation of his condition was not typical of a cervical epidural abscess. It pointed to stroke as he had motor deficit and one-sided weakness of the limbs. Weakness on both sides would have been more typical of a spinal infection. There was no sensory deficit. Motor deficit coupled with sensory deficit would have pointed to a spinal infection. For two days, his condition was stable. The initial treatment had to be given a chance to work. When the plaintiff's condition worsened on the third day, further investigations, including an MRI of the spine at the neck and upper chest level, revealed the suspected cervical epidural abscess, which was confirmed on surgery.

On that third day, Dr Ashok himself did not suspect a cervical epidural abscess but later that day Dr Chow ordered the MRI of the spine which led to the finding of the abscess.

MEDICAL LITERATURE

[94] In this regard, the medical literature bearing para 29.43 and 29.44 in *Medical Negligence* (2nd Ed) by Michael J Powers and another cited for the plaintiff, where relevant, merits reproduction as follows:

> 29.43The commonest neurological medico-legal problems arising from spinal cord lesions are due to the failure to recognise the lesion early. Spinal cord trauma is more often encountered by orthopaedic or general surgeons. Neck trauma is particularly difficult to detect quickly. Trauma at the level of C6/C7 may be missed easily and later a patient develop rapidly progressive disability. Lesions can progress slowly within the spinal canal with only minimal symptoms and perhaps no signs, until suddenly there is a rapid progression of the symptoms and signs with irreversible changes. A central disc lesion may cause bladder symptoms without much else and it can be possible to miss such a diagnosis. An operation or treatment carried out too late for a condition which if it had been treated earlier was remediable has important medico-legal implications. It is therefore essential for doctors to take seriously relatively minor symptoms in the limbs, bowel or urinary systems if they could remotely be associated with spinal cord disease. *It is impractical and unreasonable to investigate all the minor symptoms which may present but it is necessary for the doctor to include in his advice to the patient: 'Come and see me again at once if the condition worsens or alters'.* A neurologist should include this advice in his letter to a general practitioner otherwise the general practitioner may be lulled into a sense of false security concluding that because the patient had seen a consultant neurologist there was no more need for him to remain concerned. Suspected spinal cord disease should be investigated early...
>
> 29.44A doctor must be concerned that he might miss a spinal cord compression in his patient.

[95] The above medical literature makes it plain that 'a duty to take seriously relatively minor symptoms in the limbs, bowel or urinary systems' arises 'if they could remotely be associated with spinal cord disease'. In this case, there was nothing before the afternoon of 26 March 1998 to even remotely suggest any spinal cord disease.

[96] It is significant that in para 29.43, the writers said that it is impractical and unreasonable to investigate all the minor symptoms which may present.

[97] The article *Spinal Epidural Abscess: A Diagnostic Challenge*, Deardre Chao, April 2002 relied on by the plaintiff clarifies that spinal epidural abscess is a difficult diagnosis to make. The author opines that the presentation of spinal epidural abscess can be non-specific. Fever, malaise and back pain are the most consistent early symptoms.

[98] In *The Spine* by Rothman and Simeone, MD (3rd Ed) the author writes:

> Clinical Presentation. Patients with an epidural abscess have a highly variable presentation, which causes initial misdiagnosis in approximately 50 per cent of cases. The difficulty in making the correct diagnosis frequently leads to long delays between presentation and definitive treatment.
>
> The transition from one stage to another is highly variable, and weakness or paralysis may not develop for many months or may occur suddenly and unpredictably in a matter of hours.

[99] The evidence of the aforesaid witnesses for the plaintiff did not point to the failure in the standard of care on the part of Dr Lim or Dr Chow.

[100] The expert evidence and relevant medical literature points to the proper practice of sequential investigations, undertaken day by day, taking into account the plaintiff's condition, and looking for the more common problem first. It is unreasonable for a doctor to suspect first a rare condition when the symptoms and signs point to a different but much more common condition.

[101] In the circumstances, applying the *Foo Fio Na* test, I am of the view that:

(1) Upon close scrutiny, evaluation and logical analysis, I am of the view that the professional conduct of Dr Lim and and Dr Chow is consistent with the appropriate standard of care expected to be exercised by either of them as specialist in their respective field of medical practice.

(2) The plaintiff has failed to establish that Dr Chow has not exercised the standard of care in the diagnosis and treatment of the plaintiff.

(3) In relation to Dr Lim and Dr Chow, the answer to each of the above questions is therefore in the negative.

THE FIRST DEFENDANT'S LIABILITY

[102] The first defendant's vicarious liability does not arise as no liability has been attributed to Dr Lim and Dr Chow.

CONCLUSION

[103] On the foregoing grounds, I am constrained to dismiss the plaintiff's claim with costs.

Plaintiff's claim dismissed with costs.

Reported by Andrew Christopher Simon